COMPLETION OF FORM DPA 2390
ABORTION PAYMENT APPLICATION

Note: If any of the following items are not completed as outlined below, the invoice and the Payment Application Form will be returned to the provider. Entries must be typed or printed in black ink.

ITEM	INSTRUCTIONS
Recipient Name	Must be recipient's first and last name.
Recipient's Address	Must be completed with recipient's address.
Recipient's Case Identification Number	Must be completed with recipient's case identification number.
Recipient I.D. Number:	Must be completed with recipient's I.D. number. Must match recipient's I.D. number on invoice.
Location	Must be the facility name and address where procedure was performed. If procedure was performed in an office setting, enter the name and address of the physician or clinic.
Date	Must be the date service was performed.
Abortion Reason	Circle one procedure code only indicating why and how the procedure was performed. Must match procedure code on the invoice.
Physician Performing Abortion	Print the physician's full name.
Medicaid Provider Number	Enter the provider's medicaid number or state license number.
Street Address	Enter the provider's office street address.
City, State, Zip	Enter the provider's office city, state, and zip code.
Signature of Physician Performing Abortion	This is an original signature in black ink of the physician who performed the abortion.
Date	Enter the date the physician signed the application.

Illinois Department of Public Aid

Abortion Payment Application

Recipient Name

Recipient Case Identification No. _____ Recipient Identification No.

Address

I performed an abortion for the patient named above

at _____ on _____.
Location (Name, City) Date

The abortion was performed because:

	(Circle one code only) Surgical	Mifepristone
The abortion was necessary due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.	W7452	W7576
The recipient reported that the pregnancy was the result of rape.	W7462	W7577
The recipient reported that the pregnancy was the result of incest.	W 7463	W7578
The abortion was necessary to protect the woman's health.	W7599	W7579

I understand that completion of this form is for Medical Assistance payment purposes only.

_____ _____
Physician performing abortion (Please Print) Medicaid Provider Number

_____
Street Address

_____ _____ _____
City State Zip

_____ _____
Signature of physician performing abortion Date

Completion mandatory, Il. Rev. Stat., Ch. 23, P.A. Code. Penalty non-payment.
Forms approved by the Forms Management Center.